LEGISLATIVE AUDIT COMMISSION

Program Audit
Office of the Inspector General
Department of Human Services

December 2006

622 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

PROGRAM AUDIT

Program Audit
Office of the Inspector General

OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HUMAN SERVICES

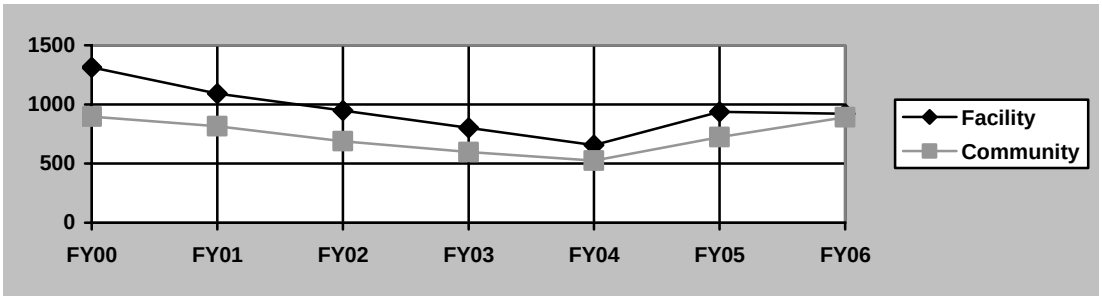
DECEMBER 2006
Recommendations - 14

The Program Audit of the Office of the Inspector General, Department of Human Services was conducted by the Office of the Auditor General pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. The Act states that the audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse and make recommendations for sanctions to DHS and the Department of Public Health. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The Inspector General during FY04 was Dr. Sydney R. Roberts. She served as Inspector General from May 2003 until her resignation in July 2005. Deputy Inspector General Robert Furniss served as Acting Inspector General from August 2005 until February 21, 2006 when Dr. William Davis was appointed Inspector General. He had no previous association with the Office.

The General Assembly established the Office of the Inspector General (OIG) in 1987. The purpose of the OIG is to investigate allegations of abuse or neglect reported within State-operated facilities and programs serving the mentally ill and developmentally disabled, as well as at facilities or programs licensed, certified or funded by DHS. In FY06, DHS operated 18 State facilities and licensed, certified, or funded over 400 community agencies. The 18 facilities served 13,417 individuals. The 367 community agency programs provided services to approximately 21,000 individuals with developmental disabilities and approximately 175,427 individuals with mental illness.

Allegations of abuse and neglect reported to the OIG had been steadily declining between 2000 and 2004; however there were 1,485 allegations of abuse in FY06 compared to 977 in FY04. In FY04 there were 206 neglect allegations reported to the OIG compared to 329 in FY06. OIG officials attribute the increased allegations to OIG's increased training on reporting requirements and to increased correspondence with facilities and community agencies. The OIG also notes that some of the increase in abuse allegations in FY05 was due to a few individuals from a facility in the South Bureau making frequent and typically unfounded allegations.

Allegations of Abuse and Neglect



Program Audit
Office of the Inspector General

This is the ninth audit of the Department of Human Services' Office of the Inspector General. The following are some of the audit's conclusions.

- While the OIG made improvements in the timeliness of investigations, 48 percent of investigations were not completed in 60 calendar days (29 percent were not completed within 60 working days) in FY06. Furthermore, a potential for future timeliness problems exists due to increased investigator caseloads and an increased number of allegations of abuse and neglect reported.
- OIG Directives require "critical" interviews to be completed within 5 working days but do not define what a "critical" interview is. Auditors found on average it took 12 days to complete interviews with the alleged victim and 25 days to complete interviews with the alleged perpetrator.
- The OIG does not define physical harm; therefore, there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect.
- An alleged criminal act (rape) was reported to the OIG but was closed by the Hotline as a non-reportable allegation. While OIG officials noted that it was reported to local law enforcement, it was not reported to the Illinois State Police as required by law.
- The OIG is required to report individuals to the Nurse Aide Registry when the OIG has substantiated a finding of abuse or egregious neglect against them. In 22 of the 28 (79%) Registry cases appealed in FY05, the petitioners won their appeal. In FY06, 19 of the 32 (59%) petitioners that have had their hearing won their appeal. When the petitioner wins the appeal, OIG's substantiated finding is not listed on the Nurse Aide Registry.
- The Administrative Law Judge (ALJ) rejected 11 cases investigated during FY05 or FY06 that were referred to the Registry. In the 11 referrals, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Registry.
- The Quality Care Board did not meet at all during FY05, and it did not meet during the first quarter of FY06.

In FY06, the OIG substantiated abuse or neglect in 210 of 1,657 closed investigations of incidents reported to the OIG. Seven percent of the cases in facilities were substantiated, while 20% of the cases in community agencies were substantiated.

As of July 2006, the OIG had 59 employees, including four on leave. This represents a decrease of one position from staffing levels reported in the FY04 audit. Investigative staff for abuse or neglect decreased from 39 in FY2000 to 27 in FY02, 22 (including two investigators on leave) in FY04, to 21 (including three on leave) in FY06.

According to Appendix A, the OIG closed 1,753 cases in FY05 and 1,799 cases in FY06. There are 18 allegation descriptions divided into three categories: abuse, neglect, and death. More than 51% of all allegations are described physical abuse without serious

harm alleged. The percentage of allegations substantiated was 11% in FY05, and 12% in FY06. The percentage of allegations substantiated in FY06 at the individual DHS facilities varied from 0% at Madden to 26% at Murray for seven cases. Kiley had the greatest number of substantiated cases—11, or 23%. A total of 154, or 18% of cases were substantiated from all the community agencies.

Recommendations

1. **Ensure that all allegations reported to the Hotline are investigated appropriately as required. Additionally, consider revising the Investigative Directives and Administrative Rule to ensure that all potential allegations of abuse and neglect are investigated.**

Findings: DHS facilities and community agencies are required to report allegations of abuse and neglect by calling into the OIG Hotline. The OIG Hotline investigator assesses whether the allegation is abuse or neglect, the intent being to reduce the number of inappropriate cases from being investigated. Hotline investigators directly enter the information into a database and the case is then forwarded to the bureaus to begin the investigation. According to OIG officials, non-reportable allegations that are reported to the OIG Hotline are not entered into the database; however, a manual record is created.

Facility and community agency employees are required to report to the OIG if they: witness, are told of, or have reason to believe an incident of abuse, neglect, or death has occurred. Rule 50 (59 Ill. Adm. Code) requires that the following allegations be reported:

- any allegation of abuse by an employee;
- any allegation of neglect by an employee, community agency, or facility; and
- any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect is suspected.

During a review of allegations reported, the auditors determined there were allegations reported that were deemed non-reportable by Hotline investigators that may have met the necessary criteria to be reported. Below are examples of allegations reported to Hotline investigators that may have met one of the necessary criteria to be reported and investigated, but were closed as non-reportable.

Examples of Allegations Closed as Non-reportable

- A client's mother called and alleged that her son isn't being cared for by staff. The allegation was deemed non-reportable "due to there not being an allegation of abuse or neglect against a staff-member".

- It was reported by a facility that a resident stated to staff that people are raping her. The resident could not be more specific and refused to talk. The allegation was deemed non-reportable due to no allegation against staff.

- Caller noted that a non-verbal resident who is unable to communicate has faint yellow bruises on the inside of the right bicep. The caller spoke to staff that stated they had concerns about two staff members due to observing the resident "flinch" when approached after the two staff had worked. The allegation was closed due to no observed abuse by staff and due to another resident that has a history of grabbing others by the arm to direct them.

- Staff at a day program reported that a non-verbal client who cannot communicate arrived at the Center with a red mark on her forehead and a red mark on the side of her head. Caller also stated that the client did not eat her lunch, which was unusual, was not herself, and did not want to get back on the agency van at the end of the day. The allegation was deemed non-reportable due to no allegation against staff.

Auditors reviewed all 128 allegations deemed "non-reportable" by Hotline investigators from January 1, 2006 to March 31, 2006, and questioned and discussed with the OIG 27 decisions to close allegations as non-reportable.

Seven of the non-reportable allegations questioned fell into one of two categories: 1) unexplained injuries to non-verbal patients; and 2) instances where individuals were left unsupervised for a period of time. For both types of allegations, the OIG's determination that the allegation was non-reportable may have been consistent based on the current definitions of abuse, neglect, and mental injury as defined in Rule 50. However, given its mission to prevent abuse, neglect, and mistreatment of persons with mental and developmental disabilities the OIG should investigate unexplained injuries to non-verbal patients and instances where clients were neglected and put in danger by being left unsupervised. Prior to the Rule 50 changes in January 2002, the definition of neglect in the OIG's administrative rules included endangering an individual with or without an injury.

OIG current administrative rule (Rule 50) defines abuse, neglect, and mental injury as:

- **Abuse** - any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means.

- **Neglect** - the failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition.

- **Mental Injury** - harm caused by an act or omission that precipitates emotional distress or maladaptive behavior in the individual, or could precipitate emotional distress or maladaptive behavior, including the use of words, signs, gestures or other actions toward or about and in the presence of individuals.

OIG Response: Accepted. As the auditors noted, OIG is in compliance with its statutory mandate to investigate abuse and neglect as defined in Rule 50. OIG's statutory jurisdiction covers alleged or suspected abuse/neglect, not *potential* abuse/neglect. OIG's Bureau of Hotline and Intake assesses every call for an allegation or suspicion of abuse or neglect.

Following the FY 2004 audit, OIG began the process of amending Rule 50, including revising some definitions. However, on June 5, 2006, the department's Legal Services recommended suspending the process, since some revisions would require statutory changes. Any revision to Rule 50 or to OIG's Investigative Directives must follow statutory changes.

However, a cross-bureau team in OIG is currently reviewing its Investigative Directives for needed clarifications or improvements. While some directives can be revised to improve operations without statutory changes, all revisions must be consistent with the current statute and Rule 50.

Auditor Comment: The auditors' review of Hotline referrals closed without an investigation identified instances where non-verbal clients received unexplained injuries and instances where clients were left unsupervised. Based on the documentation provided, it was unclear whether the injuries or the lack of supervision was the result of abuse or neglect. The auditors are recommending that the OIG take the necessary steps, including possibly revising its Investigative Directive or Administrative Rule, to ensure that all allegations reported to the Hotline that involve the possible abuse or neglect of a client are appropriately investigated.

Updated Response: Implemented. On October 24, 2006, OIG established an internal team to review all investigative OIG directives, to ensure that OIG investigates all allegations appropriately and consistently. On October 27, 2006, OIG revised its Directive INV 02-001 dealing with Hotline Coverage and the responsibilities and procedures the Hotline/Intake investigators must follow. Then, on February 23, 2007, an additional sixteen revised directives were approved and issued to OIG staff.

Senate Bill 1368, which is now law, moves the OIG to the DHS Act. The bill does not change any of the definitions or requirements in the law, so the Rule did not need to be changed.

2. Ensure that all allegations of suspected abuse or neglect that indicate any possible criminal act has been committed are reported to the Illinois State Police as required by law.

Findings: During fieldwork testing, the auditors found an instance where an alleged criminal act was reported to the OIG but was closed by Hotline investigators as a non-reportable allegation. While OIG officials noted it was reported to local law enforcement,

it was not reported to the Illinois State Police as required by State law. The allegation was reported by a facility that a female resident was raped by another resident. The allegation was closed by the OIG Hotline as non-reportable since there was no allegation that staff committed the abuse. The auditors questioned the OIG's decision to close this allegation as non-reportable, and as a result, the OIG has since opened an investigation.

State law requires the OIG to report any suspected abuse or neglect that indicates a possible criminal act has been committed to the Illinois State Police within 24 hours. The State Police shall investigate any report from a facility indicating a murder, rape, or other felony. Since the OIG did not investigate this allegation and closed it as non-reportable, the Illinois State Police was not notified. If the facility reported the allegation to local law enforcement, it was not documented by the OIG when the allegation was reported.

OIG Response: Accepted. The statute requires that, if OIG determines that a criminal act may have been committed, the incident is to be reported to the Illinois State Police or to an appropriate local law enforcement entity. In the only incident cited by the auditors, the facility reported that the female resident had been taken to the hospital for a rape kit, which involves automatic reporting to local law enforcement. OIG confirmed that the Cook County Sheriff's office had responded to the report, and thus notification of the Illinois State Police was not also necessary.
OIG Intake investigators will continue to ensure that non-reportable claims of rape, murder, or other felony are reported to the Illinois State Police or local law enforcement within 24 hours of determining credible evidence that a criminal act may have occurred. OIG will revise its directive to more clearly specify responsibility for this determination.

***Auditor Comment**:* Notification of the Illinois State Police, rather than a local law enforcement agency, was required by State law in this case. The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/6.2(b)) specifically requires that "the Department of State Police shall investigate any report from a State-operated facility indicating a possible murder, rape, or other felony."

Updated Response: Implemented. On December 6, 2006, OIG revised the internal form (INV 01-004) for reporting to the Illinois State Police and law enforcement to include the date and time that credible evidence was determined. Then effective February 23, 2007, OIG merged Directive INV01-004 and INV 02-006 and made corresponding revisions to INV 03-003, to more clearly specify responsibility for that determination.

3. Record data for non-reportable allegations and serious injuries in investigative database.

Finding: The OIG does not capture data related to non-reportable allegations that would enable investigators to look for patterns.

Serious Injuries

The OIG continues to consider serious injuries without an allegation of abuse or neglect to be not reportable. Until FY03, these cases were reported and were investigated by the OIG even though there was no allegation of abuse or neglect. The OIG made the interpretation that it is not required to investigate these serious injury cases and has taken the necessary steps to ensure that these cases are no longer reported or investigated. However, capturing the information for these cases in its database would enable investigators to look for patterns. In addition, it should be up to the OIG to determine if an injury was caused by abuse or neglect, and not up to the facility or community agency.

In the 2004 audit, the auditors recommended that the OIG capture data for all allegations of serious injuries in its database. Serious injuries caused by neglect may not have a direct allegation associated with them, such as incidents involving resident on resident injuries. Resident on resident incidents may be a result of neglect by staff and the OIG should consider requiring that these types of cases be reported for review and/or investigation.

OIG Response: Accepted. OIG agrees that non-reportable complaints (which includes some serious injuries) should be recorded in the database when received; with the assistance of the department's Management Information Systems, OIG expects to complete development of that capability shortly. As noted by the auditors, out of the 128 calls they reviewed, they found only one *(0.8%)* that possibly met the current definitions in Rule 50.

Rule 50 requires reporting of serious injuries only if alleged or suspected to have been the result of abuse or neglect by staff. Requiring agencies and facilities to report all other serious injuries to OIG would require a change in the statute.

Auditor Comment: As stated in the audit report, of the 128 allegations deemed "non-reportable" by Hotline staff from January 1, 2006 to March 31, 2006, auditors questioned the closing of 27 of these cases.

Updated Response: Implemented. Regarding non-reportable complaints – On December 8, 2006, OIG revised its database to capture non-reportable complaints and give them a special case number. OIG also revised how the database prints out intakes, so these non-reportable complaints are now listed along with previous allegations on new intakes, thereby displaying a more complete past history. From that date through the end of FY07, OIG received and recorded 493 non-reportable complaints in its database.

Not Accepted. Regarding serious injury – In FY 2006, OIG determined that requiring the reporting of serious injuries would necessitate a revision to Rule 50. However, on June 5, 2006, Legal Services requested this revision be put on hold, as it would necessitate statutory changes. Therefore, OIG cannot follow this part of the recommendation at this time.

4. Continue to work to improve the timeliness of investigations of abuse and neglect.

Finding: The effectiveness of an investigation is diminished if it is not conducted in a timely manner. Prior OIG investigative guidance required that investigations be completed as expeditiously as possible and should not exceed 60 calendar days absent extenuating circumstances. The OIG changed the definition of days in its administrative rules in January 2002 to be working rather than calendar days. Sixty working days generally works out to over 80 calendar days. Although the auditors will consider working days in some discussions, calendar days will be used in the analyses so that comparisons can be made over time to our prior audits.

Timeliness of investigations has been an issue in all of the eight previous OIG audits. During this audit period, the OIG made improvements in its timeliness for completing investigations. In FY04, 39 percent of OIG investigations were completed in 60 calendar days. Timeliness improved in FY05 with 55 percent and in FY06 with 52 percent completed in 60 calendar days.

In FY03, the average was 106 days and the median was 97 days. In FY04, the average increased to 109 days but the median decreased to 87 days. In FY05, the average was 70 days and the median was 54 days. In FY06, the average was 69 days and the median was 57 days.

Although there has been improvement, timeliness of cases taking longer than 60 working days to complete continued to be a problem for investigative bureaus for cases closed during FY06. The Central Bureau had the smallest percentage of cases taking longer than 60 working days with 2%. The percentage of cases taking longer than 60 working days was 20% for the South Bureau, and 55% for both the Metro and North Bureaus.

The number of OIG investigations taking more than 200 calendar days to complete has also decreased significantly from FY04. In FY04, 206 cases took longer than 200 days to complete. By FY06, the cases taking longer than 200 days to complete decreased to 38. Investigations at State facilities completed during FY06 accounted for 29% (11 of 38) of the cases that took longer than 200 days to complete and community agency investigations accounted for 71% (27 of 38).

In FY04 and FY06, the Metro Bureau had the largest percentage of investigations taking longer than 200 days with 39% and 68%, respectively. The North Bureau had 26%, and both the Central Bureau and South Bureau had 3%.

In FY06, investigations at Howe Developmental Center (36%) accounted for the largest portion of the State facility cases over 200 days old, followed by Singer Mental Health Center (27%) and Tinley Park Mental Health Center (18%).

OIG Response: Accepted. OIG agrees and reaffirms its commitment to completing investigations more quickly and efficiently without sacrificing quality. The auditors noted

that, in this audit period, OIG made substantial improvements in timeliness. In addition, the average time it took OIG to complete its investigations fell from 74 days in FY04 to 50 days in FY06, a reduction of 32%.

OIG notes that the auditors use *calendar* days when evaluating timeliness issues, even though Rule 50 has used *working* days since FY02. OIG maintains that audits should evaluate timeliness based on the legal measure governing its operation and that working days is a more accurate gauge of the actual time worked by salaried employees. OIG hopes that by the FY08 audit, six years of using working days will provide sufficient data for the auditors to evaluate trends.

The auditors also observed that the OIG now has significantly fewer investigators than in FY2000. In addition, three investigator positions are currently vacant and three others have only recently been filled. Yet, since FY05, OIG has received 52% more allegations. Further, since OIG has only two clinical investigators, their involvement can slow an investigation, as the auditors noted. Adding a third clinical investigator would improve investigative timeliness. OIG is continuing to fill positions as expeditiously as possible in a difficult fiscal climate.

Updated Response: Implemented. OIG has continued to emphasized timeliness requirements at Leadership Team meetings and continues to distribute daily, weekly, monthly and quarterly reports. In addition, on May 16, 2006, OIG increased the Intake investigators' role in investigating by allowing them to complete cases where the victim recants the allegation and to assign to OIG-authorized agencies investigations into alleged mental injury and alleged neglect without serious harm.

On January 17, 2007, OIG created the program to allow investigators to enter investigative case actions more quickly and even when temporarily not connected to the OIG database. OIG has also filled all five investigator positions vacant at the end of the audit period. Further, in May 2007, OIG obtained thirteen new tablet computers and 28 new upgraded computers for use by OIG staff to facilitate investigative efforts.

As a result, the timeliness of OIG's Rule 50 investigations has improved already. For FY 2006, OIG's Rule 50 investigations averaged 53 days per completed case, compared to the Rule's standard of 60 days per case. For the fourth quarter of FY07, OIG's average improved to 44 days per case, a 17% decrease.

5. Maintain the necessary documentation to monitor referrals to the Illinois State Police. Monitoring should be in place to ensure that the referrals are timely as required by State law.

Findings: There are several factors that may affect timeliness of case completion. These factors are discussed below. Cases referred to either the Illinois State Police or to OIG's Clinical Coordinators may add to the overall time it takes the OIG to complete cases. In addition, investigator caseloads, timeliness of investigative interviews, and timeliness of case file review may also increase the time it takes to complete cases.

In testing of FY06 cases, eight cases were referred to State Police. The OIG refers these cases to the State Police using its Checklist for Notification to the State Police. The auditors requested copies of the eight Checklists that were sent to the State Police. The OIG could not provide auditors with 3 of the 8 Checklists (38%). Additionally, the Checklist does not document when the OIG determined that the allegation should be reported to the State Police. Therefore, OIG management cannot ensure that the allegation was reported within the 24-hour reporting requirement found in the Act.

DISPOSITION OF CASES REFERRED TO STATE POLICE
Fiscal Years 2003 to 2006

	Number of Cases			
Disposition	**FY03**	**FY04**	**FY05**	**FY06**
Referred back to OIG without investigation	83	44	63	57
Declined by Prosecutor	10	1	15	5
Not Sustained	26	7	21	10
Conviction	5	2	6	0
Unfounded	5	1	2	1
Dismissed	3	0	1	1
Total	**132**	**55**	**108**	**74**

Source: OAG analysis of Illinois State Police data.

The State Police either conducts an investigation or refers the case back to OIG. In some instances, the OIG will conduct an investigation in a case even if the State Police conducted an investigation. The State Police investigation is a criminal investigation and the OIG's is administrative. According to OIG's investigative guidance, the OIG conducts no further investigative activity when the State Police accepts a case unless requested to do so by State Police. The exhibit shows the number of cases referred to State Police and the disposition of those cases.

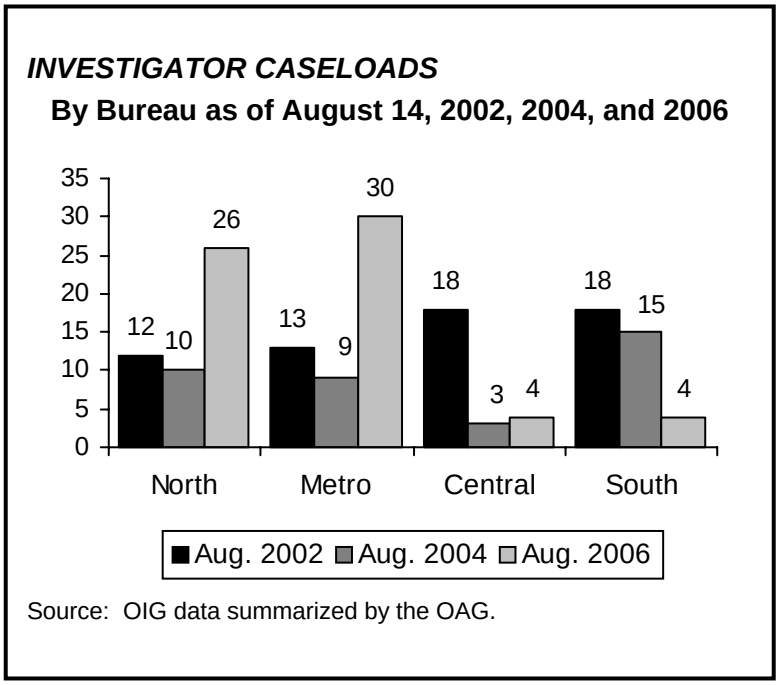
OIG Response: Accepted. OIG agrees that the documentation should show whether notification to the Illinois State Police or appropriate local law enforcement was within 24 hours of determining credible evidence of a possible criminal act. OIG has modified its law enforcement notification form to include the date and time of that determination and is currently deciding the most appropriate way to monitor timely notification.

Updated Response: Implemented. On October 24, 2006, OIG began reviewing its directives on reporting to law enforcement, to identify a process for monitoring referrals. OIG Directive INV 01-004 was subsequently promulgated on February 23, 2007, identifying this as a bureau chief responsibility.

On December 6, 2006, OIG revised the form for reporting to the Illinois State Police and law enforcement to reflect the date and time that credible evidence was determined and to more clearly specify responsibility for that determination. On July 30, 2007, the form was converted to a fillable Adobe format, to make completion easier and more consistent.

6. Take proactive measures to ensure that increased allegations, especially in the North and Metro Bureaus, do not negatively impact case completion timeliness.

Finding: Investigator caseloads may be a factor in untimely investigations in the North and Metro Bureaus. The exhibit shows that caseloads increased significantly in the North and Metro Bureaus from FY04 to FY06. The greatest increase was in the Metro Bureau where average caseloads increased by 233 percent from 9 in FY04 to 30 in FY06.



Source: OIG data summarized by the OAG.

In FY06, the highest average cases completed per month by investigator and bureau was 10.3 in the Central Bureau. The lowest monthly average cases completed per investigator was 5.1 in the North Bureau. The average days to complete a case in FY06 ranged from 33 in the Central Bureau to 124 days in the Metro Bureau. The OIG should continue to work to increase the average number of investigations completed per month for the North and Metro Bureaus to help reduce its backlog of cases in order for them to conduct more timely investigations.

Although timeliness has improved over the past two fiscal years, recent increases in the number of allegations reported will likely decrease timeliness of investigations in upcoming years. All of the investigative bureaus have had an increase in the number of allegations reported since FY04. From FY04 to FY06, allegations in the North Bureau increased by 123 percent (from 172 to 384), in the Metro Bureau by 57 percent (from 374 to 589), in the Central Bureau by 49 percent (from 310 to 463), and in the South Bureau by 39 percent (from 271 to 378). Due to the increase in reported allegations, the North Bureau had 100 investigations open at the end of FY06 compared to 50 at the end of FY04. The Metro Bureau had 120 open at the end of FY06 compared to 84 at the end of FY04.

OIG Response: OIG agrees that the North and Metro Bureaus have experienced higher caseloads and greater backlogs than the other bureaus. In addition, these two bureaus have each: lost an investigator position in the past three years; had an investigator on an extended leave of absence during the audited period; had a vacant investigator position for nearly a year; and been in the process of filling an investigator position.

To address this issue, OIG has taken the following actions:

- Established regular meetings of the investigative bureau chiefs to discuss issues and caseload;
- Assigns all investigations using a "task" function in email that alerts the supervisor when a case reaches 20 days old, so the supervisor can follow-up if it has not yet been completed;
- Revised OIG Directive INV 02-019 to further standardize a process of 30-day and over 45-day reviews for all active investigations;
- Directed that, to avoid duplicating investigative efforts, OIG investigators should, where appropriate, rely on interviews conducted by trained facility/agency investigators;
- Since June 2006, enabled the Bureau of Hotline and Intake to complete investigations when the alleged victim recants the allegation;
- Proposed allowing the Bureau of Hotline and Intake to assign and then monitor investigations of alleged mental injury to agencies that have an OIG-approved investigative protocol; and
- Is acquiring ten laptops for use by investigators, to facilitate their investigative efforts.

Updated Response: Implemented. Beginning in December 2006, OIG's investigative bureaus renewed a commitment to temporarily reassign investigations when caseloads rise. By June 30, 2007, caseloads had substantially equalized across OIG. Further, beginning July 1, 2007, OIG Intake investigators now may assign investigations (alleged mental injury and alleged neglect without serious injury only) to community agencies that have an OIG-authorized investigative protocol and have investigators trained and approved by OIG, which should reduce the caseloads in the North and Metro bureaus especially.

On January 17, 2007, OIG created a program to allow investigators to enter investigative case actions more quickly and even when temporarily not connected to the OIG database. In May 2007, OIG received thirteen laptops and 28 replacement computers for use by OIG staff to facilitate investigative efforts. The improved function will decrease the time spent on record entry, thereby shortening the time a case remains open.

7. Define in the OIG Directives what is considered to be a critical interview to provide additional guidance, and ensure that its investigative bureaus conduct investigations in a similar manner.

Findings: The number of interviews conducted by the investigative bureaus differs significantly which may be another factor relating to the timeliness of case completion. In case files reviewed, the South Bureau averaged fewer than 3 interviews per investigation during the time period, while the North averaged nearly 11 per investigation. The Central and Metro Bureaus had an almost identical average of 5.3 and 5.2 interviews per investigation, respectively. Exhibit 2-7 shows the average number of interviews per investigation by bureau.

AVERAGE NUMBER OF INTERVIEWS PER INVESTIGATION

BY BUREAU

	Number of Interviews
North	10.8
Central	5.3
Metro	5.2
South	2.9

Source: OAG sample of 126 closed investigations from FY06.

The differing number of interviews may be a result of differences in how the bureaus conduct investigations. According to OIG officials, the North investigators did not rely on statements taken by facility and agency investigators and were required to conduct interviews with all involved parties. On the other hand, the South investigators relied on the statements taken by facility and agency investigators and, as a result, conducted far fewer interviews per investigation. Another reason that the South investigators had fewer interviews on average is due to a larger number of individuals who make numerous allegations and recant the allegations almost immediately.

In FY06 the North investigators averaged 61 completed investigations annually. The investigators in the other three bureaus all averaged a higher number of investigations annually. The Metro investigators averaged 77 investigations, the Central investigators averaged 123, and the South investigators averaged 89. The higher number of interviews being conducted per investigation by the North investigators may be a factor in the bureau's low number of investigations completed annually.

OIG Response: OIG has maintained that, since each investigation is unique and requires judgment based on investigative skill and experience, it is impossible to specify what interviews are necessary and in what order, based simply upon the intake information. Important leads often develop later during the course of the investigation.

In response to an FY 2004 audit recommendation, OIG attempted to create a "critical" interview time requirement. Establishing these blanket time requirements, however, has neither provided meaningful guidance in investigations nor resulted in faster case completion. For these reasons, OIG determined that this approach is not workable and has been examining other approaches.

At the same time, OIG promulgated a standard Investigative Plan, where the investigator and supervisor identify specific leads to pursue at the outset of the investigation. OIG also mandated the use of the "task" function, to prompt an automatic 20-day review, and standardized 30-day and "over 45-day" reviews. These steps allowed for professional judgment, yet also addressed timeliness.

OIG agrees that the interview of the alleged perpetrator is vital. OIG responds that proper investigative practice often dictates this interview may take place after many, if not all, of the other interview statements and evidence have been gathered. This is another reason why adherence to a strict timetable is not applicable.

As the auditors noted, the timeliness of OIG's interviews improved greatly; the time to interview all alleged victims fell 67% from the previous audit period. OIG will continue to review this progress, building upon what has worked, in order to further improve investigative timeliness.

Auditor Comment*:* The 2004 recommendation was that the OIG "should develop specific time requirements for conducting interviews of the alleged perpetrator, victim, and any witnesses." The OIG, not the OAG, established the 5-day "critical interview" requirement. The recommendation in the 2004 audit was made as a result of auditors determining that, on average, 37 days elapsed from the time the allegation was reported until the time when the alleged victim was interviewed. In many instances, auditors had found that when the alleged victim was eventually interviewed, the victim recanted the allegation.

Updated Response: Partially Accepted. OIG has continued to seek means to ensure that all OIG cases are initiated and investigated quickly and appropriately. On May 3, 2006, OIG required investigative bureau chiefs to more closely monitor initial investigative efforts through use of an email "task" function and an Investigative Plan. Then, on February 23, 2007, OIG adopted several new directives that describe an alternate approach to the arbitrary "critical" interview time frames.

Since January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) have been conducting quarterly reviews of unfounded and unsubstantiated cases office-wide. Finally, a statewide meeting for OIG staff is planned for September 25-27, 2007, to provide opportunity for discussions and training to further ensure consistency across bureaus.

8. Improve electronic case tracking system to help manage investigations and case file review timeliness.

Finding: Timeliness of case file review has improved since the FY04 audit. However, the OIG continues to fall short of the timeline requirements in its Directive relating to case file review. Data from the OIG database shows that none of the four investigative bureaus are reviewing substantiated cases within the timelines delineated in the OIG Directives. OIG Directives require the Investigative Team Leader (ITL) and Bureau Chief to review cases within seven working days of receipt. If the case is substantiated, the case is reviewed by the Inspector General or designee.

The ITL or the Bureau Chief may send the case back to the investigator for further investigation. The Directive states that the investigator will complete the additional work and ensure that the case is returned to the ITL or Bureau Chief within seven working days of the receipt of the returned case. Once the Bureau Chief reviews and approves a substantiated case, Directives require that it be forwarded to the Deputy Inspector General for review and approval.

AVERAGE CALENDAR DAYS FROM DATE SUBMITTED FOR REVIEW UNTIL FINAL REVIEW BY BUREAU CHIEF
Fiscal Years 2004 to 2006

	Substantiated Cases [1]			**Unsubstantiated Cases [1]**		
	FY04	**FY05**	**FY06**	**FY04**	**FY05**	**FY06**
North	51	51	35	7	4	8
Metro	83	61	68	22	16	19
Central	45	29	21	5	3	9
South	61	82	28	10	6	7
Total Avg.	**60**	**50**	**36**	**13**	**8**	11

Note:
[1] Days may include time when the Bureau Chief sends the case back to the investigator for further investigation.

Source: OAG analysis of OIG data.

The exhibit shows that none of the bureaus are reviewing substantiated cases within the 7-day timeline delineated in the OIG Directive. The Metro Bureau takes much longer to review substantiated cases than the other three bureaus. The review of substantiated cases is taking a large percent of the 60-day time requirement that the OIG has to complete its investigations. Improvements in the time it takes to review substantiated cases could have a substantial effect on the overall timeliness of case completions at the OIG.

Beginning in FY06, the OIG expanded its case monitoring to include an automated case tracking system, as recommended in the 2004 OIG audit. The system is intended to assist OIG management in overseeing and managing cases. The automated system is designed to be a "real-time" system. The OIG Directives require all investigative activity be entered into the automated case tracking part of the OIG database as soon as possible, but no later than one week after completion of the activity. OIG documents note that the system allows supervisors to independently view actions and to add additional comments without requesting the case file. The OIG training documents state that Bureau Chiefs may run a series of specified reports from the case tracking system at least weekly.

During interviews with OIG supervisory staff, none of the staff felt the case tracking system was beneficial. Some of the supervisory staff responded that the case tracking system did not help to alleviate time delays, but in fact, slowed down the process since the investigators are required to enter everything twice, once handwritten, and a second time in the tracking system. Several investigators responded that the increased time entering data was taking away from their necessary investigative duties.

OIG Response: Accepted. With the help of the Department's Management Information Systems, OIG is developing a web-enabled version of the Investigative Case Actions form, which should significantly speed the entry of actions taken and allow for entry even when off-site.

OIG case reviewers have now begun entering review dates into the database to allow tracking and ensure case review timeliness.

Updated Response: Implemented. OIG continues to improve both the procedural and technical components of its electronic case management system. Initial investigative plans, tracking reports for State Police investigations, and other documents are produced from the database. On November 9, 2006, OIG required case reviewers to enter review dates into the database, and review timeliness will now be examined. Subpoenas are producible from the database as of August 8, 2007.

To increase the system's capabilities, OIG added a new process on December 8, 2006, that allows faster entry of multiple cases. In January 2007, OIG finalized a new program that allows investigators to enter investigative case actions even when off-line; these actions are automatically uploaded once the investigator goes back on-line. Finally, in May 2007, OIG finished receiving a total of 41 new computers, replacing outdated computers that delayed case completion.

9. Continue to work with State facilities and community agencies to ensure that allegations of abuse or neglect are reported within the time frame specified in OIG's administrative rule.

Finding: While there has been an improvement in the timely reporting of incidents to the OIG since the last audit in 2004, alleged incidents of abuse and neglect are not being reported by facilities and community agencies in the time frames required by OIG's administrative rule. The current administrative rules require allegations to be reported to the OIG within four hours of initial discovery of the incident of alleged abuse or neglect. In January 2002, the OIG increased the required reporting time from one hour to four hours. Community agencies continue to have a larger percentage of untimely reports with 29% compared to 6% for facilities.

ALLEGATIONS OF ABUSE OR NEGLECT NOT REPORTED WITHIN FOUR HOURS OF DISCOVERY

	Facility	Community Agency
FY03	15%	42%
FY04	10%	42%
FY05	6%	34%
FY06	6%	29%

Source: OAG analysis of OIG data.

OIG Response: Timeliness of self-reports to OIG has steadily improved, from 75% on time in FY 2003 to 83% on time in FY 2006. Since the last audit, OIG has accomplished the following:

- Wrote and sent to all facilities and agencies a handbook entitled, "Reporting and

Investigating Abuse and Neglect of Adults with Disabilities," which emphasizes timeliness;

- Created and e-mailed to all facilities and agencies a self-contained training module on Rule 50;
- Placed two automated flags on the intake form, which appear when an intake is reported late;
- Routinely cites late reporting as an issue in the investigative case report when it has occurred, which requires a Written Response from the agency or facility listing corrective actions;
- Sends monthly reports to the program divisions listing late reporting by facilities and agencies;
- Discussed the issue with the program divisions at the quarterly OIG Coordination Committee for their follow-up; and
- Proposed a new law (P.A. 94-853, effective June 13, 2006) making intentional late reporting or non-reporting a Class A misdemeanor.

Updated Response: Implemented. OIG has continued to work with agencies and facilities to report allegations in a timely manner. OIG has been reviewing agency reporting policies to ensure that they include basic requirements, such as the 4-hour time requirement for allegations to be reported to the OIG Hotline. In February 2007, OIG updated its "Handbook for Reporting Abuse and Neglect of Adults with Disabilities" to include the new law making failure to report or late reporting a Class A misdemeanor (OIG proposed this law, which was signed in 2006). In August 2007, OIG finalized an update of the Rule 50 training module it sends to all agencies and facilities to bolster training in reporting of allegations to OIG.

When late reporting occurs, OIG continues to take substantial steps to address it. OIG cites the late reporting in the investigative case report. OIG reviews facility/agency actions taken in response to late reporting during its random Written Response Compliance Reviews. OIG sends monthly reports to the DHS program divisions listing late reporting and discusses late reporting at each quarterly DHS-OIG Coordination meetings.

10. Develop criteria for documenting investigative interviews.

Finding: In response to our 2004 audit, the OIG amended its Investigative Directives. Investigators are now required to complete an Investigative Plan prior to the start of the investigation. Additionally, specific time requirements were added to the Directives. These time requirements mandate that the Investigative Plan be completed within three working days after assignment and that all critical interviews be completed within five days after approval of the Investigative Plan. The Directives were also amended to require that photographs be taken whenever an allegation of abuse or neglect is received alleging an injury, whether or not the injury is visible. With only a few exceptions, the case files sampled from FY06 were generally thorough and contained the appropriate documentation.

The OIG investigators are inconsistent in regard to the format used to document investigative interviews. In some instances, investigators use a summary format to document interviews while others use more of a question and answer format. When the summary format is used, the reviewer is unable to determine whether all appropriate and necessary questions were asked. OIG's training manual states "Do not ask leading questions." However, if the questions asked are not listed in the summary write-up, OIG management cannot be assured whether or not the appropriate questions were asked. Additionally, during file testing the auditors found five examples from five different investigations where interview write-ups were almost verbatim for multiple individuals interviewed. In many of these write-ups, the investigator used the same summary write-up and changed the time and names of the other witnesses.

OIG Response: Accepted. OIG agrees that investigative interviews should be documented, and OIG has both a directive requiring investigators to document interviews and a standard form for that purpose. Each interview is unique, however, and OIG relies on the skill and experience of the investigator and supervisor to determine the best approach to the interview and to documenting it.

Further, when reviewing the submitted case report, the supervisor ensures that all appropriate interviews were done and are accurately reflected in the report. In one instance of verbatim interview statements identified by the auditors, the witnesses had all said they were in the room and had not observed the alleged abuse. The interviews were thus short and identical. The bureau chiefs carefully review such verbatim statements to ensure that they properly record the particulars of the interviews.

The auditors highlight the training manual's guidance against asking leading questions. This sentence is under the description of the "Initial Interview." Two pages later, the manual states: "Follow-up interviews differ from initial interviews in that they are specific in nature." That is, after analyzing the initial statements, an interviewer may need to ask specific leading questions in a follow-up interview. Such questions may be appropriate in other interviews, such as with an expert or a hostile witness. Again, the interview and its documentation must rely on professional judgment.

11. Address investigative inconsistencies among bureaus as follows:

- **clearly define what constitutes physical injury and physical harm, and**
- **establish a centralized review process of substantiated, unsubstantiated, and unfounded investigations to help ensure consistency of its investigations.**

Finding: As a result of extensive file review, the auditors determined that there were inconsistencies between investigative bureaus related to how the bureaus classify allegations and findings. In addition, the inconsistencies between what is and is not accepted by the Bureau of Hotline and Intake as an allegation of abuse or neglect.

OIG's four investigative bureaus are decentralized, which has led to inconsistencies among the bureaus. There are few controls in place to ensure that the investigations by the bureaus within the OIG are consistent. While the investigative bureaus use standard forms, there is no centralized review. These standard forms include the Investigative Plan, the Case Tracking Form, the Case Routing Form, and the Case Closure Checklist. Substantiated cases of abuse or neglect are reviewed by the Inspector General or his designee to ensure consistency. However, investigations that are closed as either unfounded or unsubstantiated are closed by the Bureau Chief from each bureau and are not reviewed centrally.

Case 1 involves a client who eloped (ran away) from a CILA van and was lost for an extended period of time. This case was **substantiated** as neglect, and the employees involved were both terminated. Case 2 involves a client that was found by an off duty staff member six blocks away from his CILA walking in the middle of the street. The client's Residential Supervision Needs Assessment states that victim cannot cross streets safely alone, cannot go to or return to or from a destination in an allotted time, and cannot appropriately respond when approached by strangers. This case was determined to be **unsubstantiated**. Case 3 involves a client that did not want to cross a bridge from a building back to the home unit at the facility because she was mad at another recipient in the group. The employee instructed the client to return back to the building. The client was found three blocks away at a restaurant. The caller stated that the recipient had a history of this kind of behavior, but this case was determined to be **non-reportable** by the Bureau of Hotline and Intake because the recipient was returned to the facility without incident and was not injured.

Two mental injury investigations that were similar from two different bureaus were treated differently. Case 1 involves an employee that used profanity towards a client while distributing medications. Two other recipients witnessed the incident. The Office of the Inspector General **substantiated** mental injury with recommendations because of the "credible responses of the two witnesses". The accused employee was ultimately terminated from his job. Case 2 involves a staff person who also used profanity towards a client. This act was committed in an attempt to redirect the recipient into their room. It was determined from the investigation that three witnesses heard the staff use profanity toward the recipient. During the alleged perpetrator's interview, he stated that it was possible that he may have used profanity. This case was **unsubstantiated** with recommendations. The employee was not discharged in this instance. The Office of the

Inspector General recommended that the facility review the actions of the employee and take appropriate administrative action.

It appears that one of the reasons for the inconsistencies between the investigative bureaus may be due to different interpretations for the definition of physical harm. OIG's definitions of abuse and neglect in its administrative rules both include the term "physical injury." As seen in Exhibit 3-3, 59 Ill. Adm. Code 50.10 (Rule 50) defines physical injury as physical harm. Physical harm is not defined in the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/3) or in Rule 50.

DEFINITION OF PHYSICAL INJURY AND PHYSICAL HARM

Physical Injury

Defined as **physical harm** to an individual caused by any non-accidental act or omission.

Physical Harm

- Not defined in the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/3)
- Not defined in 59 Ill. Adm. Code 50.10
- Only defined in OIG Training Manual as a **WRONG OR INJUSTICE**

Source: OAG analysis of statutes, administrative rules, and training manual.

During a review of case files, the auditors determined that there were inconsistencies in how physical harm was interpreted relating to allegations of abuse and neglect. OIG's response was that physical harm is defined as a wrong or injustice. For example:

- In one case, a staff member thrust her hand out in front of her to protect herself after a client punched her in the eye, giving the staff member a black eye. The client had no visible injury when examined. The staff member sought medical treatment for her injury. The OIG **substantiated abuse** in this case, and the staff member was dismissed from her job.

- In another case, a staff person found recipient alone walking in the middle of the street six blocks away from the CILA. The recipient's plan says he cannot cross streets safely and cannot go to or return from a destination in an allotted time. Plan notes victim "will elope from designated areas." The OIG **unsubstantiated neglect** with other issues in this case because it concluded the recipient did not suffer any injuries or harm during the elopement.

Another factor that contributes to inconsistencies in OIG's findings is that all closed investigations are not reviewed in a similar manner. Investigative Bureau Chiefs are allowed to close unsubstantiated and unfounded investigations without any other review. Substantiated investigations are reviewed by the Bureau Chiefs and then by either the Inspector General or a designee. Inconsistencies between substantiated, unsubstantiated, and unfounded findings may have been identified by the OIG if all

closed investigations were reviewed in the same manner. Rule 50 defines unfounded as "no credible evidence to support the allegation that abuse or neglect occurred."

To ensure that clients are being protected, the OIG should make sure that its investigative bureaus conduct investigations in a consistent manner. The Inspector General should clearly define what constitutes physical injury and physical harm. Additionally, the Inspector General should ensure that all closed cases whether substantiated, unsubstantiated, or unfounded are reviewed by either himself or a designee to ensure consistency.

OIG Response: Accepted. OIG believes that the issue of definitions would be resolved by revisions to the statute. Until the statute is revised, however, such a change to Rule 50 would be premature. However, in the meantime, OIG will reinforce that physical "harm" is a physical " wrong or injustice."

Since one designee could not adequately review 2,000 cases/year nor spot every inconsistency, OIG will instead implement quarterly reviews conducted by the Deputy Inspector General and one investigative bureau chief selected on a rotating basis. The reviews will examine a sampling of unfounded and unsubstantiated cases to ensure consistency across bureaus. Findings will be discussed at OIG Leadership Team meetings and at investigative bureau chiefs' meetings.

Updated Response: Partially Accepted. OIG cannot revise the definitions in Rule 50 until the statute has been changed. However, to address ensuring consistency, beginning in January 2007, the Deputy Inspector General and one investigative bureau chief (on a rotating basis) conduct quarterly reviews of unfounded and unsubstantiated cases office-wide to ensure consistency in approaching and findings across the bureaus. On February 22, 2007, OIG began discussing the findings of the quarterly reviews at OIG Leadership Team meetings: so far, no inconsistencies have been found between the bureaus in understanding of investigative evidence or findings.

12. Review ALJ rulings to determine the reasons why referrals to the Nurse Aide Registry are rejected by the ALJ and whether changes to the investigative process are warranted; and ensure the safety of individuals with mental or physical disabilities receiving services in the State of Illinois by making appropriate revisions to administrative rules, policies or procedures (which may include revising the definition of egregious) to ensure that all cases with findings that warrant reporting to the Nurse Aide Registry are reported.

Finding: The Department of Public Health maintains the Nurse Aide Registry that lists of individuals who have been trained as nurse aides for hospitals, nursing homes, and other settings with medically involved persons. By law, no facility, service agency, or support agency providing mental health or developmental disability services hat is

licensed, certified, operated, or funded by the Department shall employ a person, in any capacity, who is identified by the nurse aide registry as having been subject of a substantiated finding of abuse or neglect of a services recipient.

The OIG referred 81 substantiated cases to the Nurse Aide Registry in FY05 and 47 in FY06. Of these 128 cases, only 2 (1.6%) were sent for substantiated egregious neglect while the other 126 were for substantiated abuse.

In the review of the Nurse Aide Registry appeals requested, 28 substantiated cases were appealed in FY05 and 36 cases were appealed in FY06. In FY05, 22 of the 28 (79%) petitioners won their appeal, and in FY06, 19 of the 32 (59%) petitioners that have had their hearing won the appeal, which means the OIG's substantiated finding is **not** listed in the Nurse Aide Registry.

By rule, DHS is required, in the event an employee appeals an OIG substantiated finding, to demonstrate by a preponderance of the evidence that the finding warrants reporting to the Nurse Aide Registry. Rule 50 defines preponderance of the evidence as proof sufficient to persuade the finder of fact that a proposition is more likely true than not true.

The auditors reviewed all 11 substantiated cases referred to the Nurse Aide Registry that were rejected by the DHS administrative law judge (ALJ) in FY06. These 11 cases were investigated by the OIG during the FY05-FY06 audit period. In the 11 referrals that were rejected, the ALJ found that the Department had not demonstrated by a preponderance of the evidence that the finding of abuse against the petitioner warranted reporting to the Nurse Aide Registry. In 4 of the 11 referrals (36%), the ALJ concluded that the evidence presented at the hearing was conflicting or insufficient to determine that the Petitioner committed the act.

During fieldwork, auditors reviewed numerous case files at the OIG. The review included looking at the ALJ rulings for cases reported to the Nurse Aide Registry. During the review, auditors questioned the adequacy and consistency of findings being reported to the Nurse Aide Registry. The auditors identified two substantiated cases of physical abuse that were referred to the Nurse Aide Registry where the ALJ found that the two staff members acted instinctively toward a client after the client either inappropriately touched or punched the staff.

In comparison, auditors found a case where a recipient was physically injured as a result of a community agency employee's actions. Based on the actions by the employee, the allegation appears to meet the definition of physical injury as defined by the OIG. A "wrong or injustice" to the recipient is the standard used by the OIG to substantiate physical injury in an abuse case. The case was categorized by the OIG as neglect, not abuse, and was therefore not reported to the Nurse Aide Registry.

The OIG determined that the neglect was not egregious based on its definition as defined in its administrative rule. Rule 50 defines egregious neglect as:

> *The substantive failure by an employee to provide adequate medical or personal care or maintenance that results in the death, serious medical condition, or serious deterioration of an individual's physical or mental condition, as determined by the Inspector General.*

However, a separate investigative report written by the community agency's investigator stated it would constitute egregious neglect. OIG's definition of egregious did not allow the OIG to consider the injury (which needed stitches) and cold temperature, or insensitive nature of the allegation to factor into the decision as to whether or not the neglect was egregious. As a result, this case was not referred to the Nurse Aide Registry. The OIG's definition of egregious may be the primary factor why only 2 of 128 (1.6%) cases referred to the Nurse Aide Registry during FY05 and FY06 were for neglect.

In one case, a staff member allegedly pushed a client in self-defense after being punched in the face. Using OIG's current definitions, the staff member received a substantiated finding of abuse by the OIG and the finding was referred to the Nurse Aide Registry. In another case, a staff member pushed a client in a wheelchair outside in 10-degree weather and locked the door. The client became agitated and broke a window resulting in an injury to his hand requiring three stitches at the emergency room. The staff member received a finding of substantiated neglect and the finding was not reported to the Nurse Aide Registry.

Response: OIG agrees and, since FY 2005, has been reviewing every decision in Registry referral appeals. No problems with the investigator process have been found.

The statute mandates that OIG refer the names of all persons substantiated to have committed physical abuse, sexual abuse, or egregious neglect, regardless of the severity of the act. However, the statute provides for an appeals process, granting the ALJ the discretion to determine that the act was not severe enough to warrant referral to the Registry. That is, the appeal is to address the referral, not the finding.

After reviewing several decisions by the ALJ upholding appeals, OIG initiated a dialog with the department's Legal Services to develop some constructive approaches to the appeals process. These discussions culminated in the following three specific actions:

- OIG completed development of an in-house training on testifying at court hearings.
- OIG designated a legal liaison to help prepare the department attorney who is assigned to represent OIG at a Registry appeals hearing.
- DHS Legal and OIG established a process authorized by the code governing these hearings for stipulating that certain physical abuse cases, while meeting the broad definition of physical abuse, did not deserve placement on the Registry. This new process was approved by the department on September 11, 2006. It is triggered by a 50.90 petition and includes input from the petitioner, OIG and DHS Legal while leaving the final decision with the ALJ and the Secretary of DHS.

Ensuring the safety of individuals remains OIG's highest priority. OIG agrees with the auditors that Registry referrals have been consistent with the current Rule 50 definitions. If OIG has the opportunity to propose changes to the statute, the definitions would be a focal point. Revisions to Rule 50 and the Directives would follow. By ensuring appropriate referrals, this would help prevent abuse/neglect.

Updated Response: Implemented. Since May 2006, OIG has been routinely reviewing ALJ's opinions, so that OIG can take revise its investigative process, if necessary, and participate effectively in the appeals process. An outcome of these reviews has been that, on September 11, 2006, OIG implemented a new stipulation process, developed jointly by OIG and the Office of the General Counsel, for certain physical abuse cases. Another outcome has been that, on December 4, 2006, OIG finalized a training of its investigators on testifying at court hearings; the training was conducted on March 30 and April 5, 2007.

13. Continue to work with the Quality Care Board to assure that the Board meets quarterly as required by statute.

Finding: During FY05 and FY06, the Quality Care Board (Board) did not have seven members as required by statute. The statute also states that the Board is to meet quarterly and that four Board members constitute a quorum.

During the last audit, only four members had been serving on the Board since September 2002. In June 2004, Board membership decreased to three when one of the remaining Board members resigned. In September 2004, the three remaining Board members' terms expired, leaving the Board without any members.

In June and July of 2005, the Governor appointed 5 members to the Board: four new appointments and one reappointment. By the end of this audit period, June 30, 2006, there were still only five members serving on the Board, with two vacancies. However, the two vacant positions were filled in September 2006. In addition, the Quality Care Board did not meet statutory requirements regarding quarterly meetings. The Board did not meet at all during FY05, and it did not meet during the first quarter of FY06. According to an OIG official, there was not a Quality Care Board in FY05 because all of the members' terms had expired. However, after the Governor appointed five members to the Board, it met twice in the second quarter of FY06: October 2005 and December 2005. The Board also held a meeting in February 2006 and May 2006, but the May meeting failed to have a quorum.

Response*:* OIG agrees. The Quality Care Board has full membership as of September 2006 and is meeting quarterly as required. As noted by the auditors, the Board is fulfilling its statutory requirements to monitor and oversee the operations, policies and procedures of OIG to ensure the thorough and prompt investigation of abuse/neglect allegations.

Updated Response: Implemented. The OIG Quality Care Board met once each quarter in FY07.

14. Ensure that established timelines are met for submitting site visit reports to facility directors or hospital administrators.

Finding: During FY05 and FY06, the OIG did not always comply with its established timeline for submitting site visit reports to facility directors or hospital administrators. OIG Directives state that site visit reports should be submitted to facility directors or hospital administrators within 60 days of the completion of the site visit. In FY04, all of the site visit reports were completed and sent to the facility directors or hospital administrators within the required timeline. In FY05, 10 of the 18 (56%) mental health and developmental centers received a site visit report after the 60-working day timeline. In FY06, 6 of the 18 (33%) centers received a site visit report after the timeline. According to an OIG official, at the end of October 2004, one of the two regular site visitors resigned and the remaining site visitor had several other time-sensitive duties, which resulted in a delay in completing site visit reports. The official also stated that during FY06, some site visit reports were delayed due to high priorities such as completing case reports, death reviews and other statutory requirements.

Response: OIG agrees and notes that the auditors found that OIG's site visitors focused on relevant issues, effectively applied standard procedures, and provided useful information to the facilities. Since OIG's site visitors discuss the findings with the facility administrators at an exit conference when the site visit concludes, corrective actions are not prevented by a delay in the written report.

During FY 2005, one of the two administrative site visitors resigned and that position has not been filled; then, during FY 2006, the administrative site visitor covering the other half of the state also resigned. Still, OIG has completed all the required site visits using existing staff who have other responsibilities. During FY 2005, OIG mailed 8 of the 18 site visit reports (*44%*) on time; during FY 2006, OIG mailed 14 of the 18 site visit reports (*78%*) on time.

Updated Response: Implemented. OIG completed all eighteen FY07 unannounced site visit reports within sixty working days.